# Patient Education
# January 2005

1: Am Fam Physician. 2004 Dec 15;70(12):2299-306.

Comment in:
Am Fam Physician. 2004 Dec 15;70(12):2272, 2274.

The patient with daily headaches.

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The term "chronic daily headache" (CDH) describes a variety of headache types, of which chronic migraine is the most common. Daily headaches often are disabling and may be challenging to diagnose and treat. Medication overuse, or drug rebound headache, is the most treatable cause of refractory daily headache. A pathologic underlying cause should be considered in patients with recent-onset daily headache, a change from a previous headache pattern, or associated neurologic or systemic symptoms. Treatment of CDH focuses on reduction of headache triggers and use of preventive medication, most commonly anti-depressants, antiepileptic drugs, and beta blockers. Medication overuse must be treated with discontinuation of symptomatic medicines, a transitional therapy, and long-term prophylaxis. Anxiety and depression are common in patients with CDH and should be identified and treated. Although the condition is challenging, appropriate treatment of patients with CDH can bring about significant improvement in the patient's quality-of-life.

Publication Types:
Review
Review, Tutorial
PMID: 15617293 [PubMed - indexed for MEDLINE]

2: Am Fam Physician. 2004 Dec 1;70(11):2157-64.

Summary for patients in:
Am Fam Physician. 2004 Dec 1;70(11):2171-2.

Outpatient treatment of systolic heart failure.

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Optimal outpatient treatment of systolic heart failure has three goals that should be pursued simultaneously: (1) control of risk factors for the development and progression of heart failure, (2) treatment of heart failure, and (3) education of patients. Control of risk factors includes treating hypertension, diabetes, and coronary artery disease, and eliminating the use of alcohol and tobacco. All patients with heart failure should be taking an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker. In the absence of contraindications, an ACE inhibitor is preferred. In most patients, physicians should consider adding a beta blocker to ACE-inhibitor therapy. In patients with severe heart failure, spironolactone is a useful addition to baseline drug therapy, as is carvedilol (substitute carvedilol if patient is already taking a beta blocker). Patients with stable heart failure should be encouraged to begin and maintain a regular aerobic exercise program. Digoxin therapy may reduce the likelihood of hospitalization but does not reduce mortality. It must be monitored closely, with a target dosage level of 0.5 to 1.1 ng per mL. Symptoms may be controlled with the use of diuretics and restricted dietary sodium. Finally, patient education, with the patient's active participation in the care, is a key strategy in the management of heart failure. Periodic follow-up between scheduled office visits, which is essential in the long-term management of heart failure, may include telephone calls from the office nurse, maintenance of a daily symptom and weight diary, and participation in a disease-management program.

Publication Types:
Review
Review, Tutorial
PMID: 15606064 [PubMed - indexed for MEDLINE]

3: Arch Phys Med Rehabil. 2004 Dec;85(12):1915-22.

A short course of cardiac rehabilitation program is highly cost effective in improving long-term quality of life in patients with recent myocardial infarction or percutaneous coronary intervention.

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OBJECTIVE: To evaluate the long-term effect of a cardiac rehabilitation and prevention program (CRPP) on quality of life (QOL) and its cost effectiveness. DESIGN: Prospective, randomized controlled trial. SETTING: University-affiliated outpatient cardiac rehabilitation and prevention center. PARTICIPANTS: A total of 269 patients (76% men; mean age, 64+/-11 y) with recent acute myocardial infarction (AMI; n=193) or after elective percutaneous coronary intervention (PCI; n=76) were randomized in a ratio of 2 to 1. INTERVENTION: Patients received either CRPP (an 8-wk exercise and education class in phase 2) or conventional therapy without exercise program (control group). They were followed until they had completed all 4 phases of the program (ie, 2 y). MAIN

OUTCOME MEASURES: QOL assessments, by using the Medical Outcomes Study 36-Item
Short-Form Health Survey (SF-36) and Symptoms Questionnaire, were performed at the end of each phase. Direct health care cost was calculated, whereas cost utility was estimated as money spent (in US dollars) per quality-adjusted life-year (QALY) gained. RESULTS: In the CRPP group, 6 of the 8 SF-36 dimensions improved significantly by phase 2 and were maintained throughout the study period. Patients were less anxious and depressed, and felt more relaxed and contented. In the control group, none of the SF-36 dimensions were improved by phase 2, and bodily pain was increased. In phase 4, only 4 dimensions were improved. Symptoms were unchanged except for increased hostility score. There was a significant gain in net time trade-off in the CRPP group after phase 2. The direct health care expenses in the CRPP and control groups were 15,292 dollars and 15,707 dollars per patient, respectively. Therefore, the cost utility calculated was 640 dollars saved per QALY gained. Savings attributable to CRPP were primarily explained by the lower rate (13% vs 26% of patients, chi2 test=3.9, P <.05) and cost of subsequent PCI (P =.01). CONCLUSIONS: In an era of managing patients with coronary heart disease, a short-course CRPP was highly cost effective in providing better QOL to patients with recent AMI or after elective PCI. In addition, the improvement of QOL was quick and sustained for at least 2 years after CRPP.

Publication Types:
Clinical Trial
Randomized Controlled Trial
PMID: 15605326 [PubMed - indexed for MEDLINE]

4: Arch Ophthalmol. 2004 Dec;122(12):1788-92.

Expectations and outcomes in cataract surgery: a prospective test of 2 models of satisfaction.

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OBJECTIVES: To document patients' preoperative expectations for postoperative outcomes. To measure the relative contribution of patient understanding, expectations, outcome, and expectation-outcome discrepancy in determining patient satisfaction. METHODS: One hundred twenty-one patients were surveyed just before and 1 month after cataract surgery regarding their understanding of the procedure, satisfaction with their vision, and both current and expected visual function for each of the items on the Visual Function Index (VF-14). RESULTS: Sixty percent of patients expected to achieve a perfect VF-14 score. The average expected VF-14 score was 96.1, compared with an achieved VF-14 score
of just 89.8. The most unrealistic expectations involved driving at night, reading small print, and doing fine handiwork. Surprisingly, improvement in visual function was not correlated with satisfaction in vision. While patient understanding, expectations, and achieved VF-14 score did correlate with satisfaction, when controlling for other factors, only achievement-expectation discrepancy was independently predictive. CONCLUSIONS: This study provides support for the expectation-outcome discrepancy model of patient satisfaction.

Further, it highlights the highly unrealistic expectations harbored by patients with cataract and emphasizes the importance for physicians to control their patients' expectations. Controlling patient expectations may be more effective than improving patients' postoperative outcome in terms of maximizing patient satisfaction.
PMID: 15596581 [PubMed - indexed for MEDLINE]

5: Mayo Clin Proc. 2004 Dec;79(12):1533-45.

Contemporary management of neuropathic pain for the primary care physician.

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Neuropathic pain (NP), caused by a primary lesion or dysfunction in the nervous system, affects approximately 4 million people in the United States each year. It is associated with many diseases, including diabetic peripheral neuropathy, postherpetic neuralgia, human immunodeficiency virus-related disorders, and chronic radiculopathy. Major pathophysiological mechanisms include peripheral sensitization, sympathetic activation, disinhibition, and central sensitization. Unlike most acute pain conditions, NP is extremely difficult to treat successfully with conventional analgesics. This article introduces a contemporary management approach, that is, one that incorporates nonpharmacological, pharmacological, and interventional strategies. Some nonpharmacological management strategies include patient education, physical rehabilitation, psychological techniques, and complementary medicine. Pharmacological strategies include the use of first-line agents that have been supported by randomized controlled trials. Finally, referral to a pain specialist may be indicated for additional assessment, interventional techniques, and rehabilitation. Integrating a comprehensive approach to NP gives the primary care physician and patient the greatest chance for success.

Publication Types:
Review
Review, Tutorial
PMID: 15595338 [PubMed - indexed for MEDLINE]

6: Arthritis Rheum. 2004 Dec 15;51(6):1045-59.

Systematic review of rheumatoid arthritis patient education.

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Publication Types:
Review
Review, Tutorial

PMID: 15593105 [PubMed - indexed for MEDLINE]

7: Sex Transm Infect. 2004 Dec;80(6):484-7.

Can mainstream services learn from male only sexual health pilot projects?

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Over the past decade a number of community based sexual health projects aimed solely at young men have proved to be very successful at attracting young men into genitourinary medicine services. These projects are often short term funded and under evaluated so it isn't clear exactly how successful they are and why this might be so. These projects should be carefully evaluated and examined to elicit factors, either unique or common in nature, which could be utilised by mainstream sexual health services wishing to develop work with young men. There are many barriers to this happening in mainstream services, some being resource and time problems and others to do with values of staff and lack of quality training. The article looks at practical ways that working with men and the skills and confidence of staff can be improved in mainstream settings while recognising that much of what needs to be done to support the needs of young men must take place in the planning and commissioning stage of services.
PMID: 15572620 [PubMed - indexed for MEDLINE]

8: Laryngoscope. 2004 Dec;114(12):2135-46.

Auditory brainstem implantation in patients with neurofibromatosis type 2.

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OBJECTIVES: Multichannel auditory brainstem implants (ABI) are currently indicated for patients with neurofibromatosis type II (NF2) and schwannomas involving the internal auditory canal (IAC) or cerebellopontine angle (CPA), regardless of hearing loss (HL). The implant is usually placed in the lateral recess of the fourth ventricle at the time of tumor resection to stimulate the cochlear nucleus. This study aims to review the surgical and audiologic outcomes in 18 patients implanted by our Skull Base Surgery Team from 1994 through 2003. STUDY DESIGN: A retrospective chart review of 18 patients with ABIs. METHODS: We
evaluated demographic data including age at implantation, number of tumor resections before implantation, tumor size, surgical approach, and postoperative surgical complications. The ABI auditory results at 1 year were then evaluated for number of functioning electrodes and channels, hours per day of use, nonauditory side effect profile and hearing results. Audiologic data including Monosyllable, Spondee, Trochee test (MTS) Word and Stress scores, Northwestern University Children's Perception of Speech (NU-CHIPS), and auditory sensitivity are reported. RESULTS: No surgical complications caused by ABI implantation were revealed. A probe for lateral recess and cochlear nucleus localization was helpful in several patients. A range of auditory performance is reported, and

two patients had no auditory perceptions. Electrode paddle migration occurred in two patients. Patient education and encouragement is very important to obtain maximum benefit. CONCLUSIONS: ABIs are safe, do not increase surgical morbidity, and allow most patients to experience improved communication as well as access to environmental sounds. Nonauditory side effects can be minimized by selecting proper stimulation patterns. The ABI continues to be an emerging field for hearing rehabilitation in patients who are deafened by NF2.
PMID: 15564834 [PubMed - indexed for MEDLINE]

9: Anesth Analg. 2004 Dec;99(6):1766-73, table of contents.

Anesthesiologists, general surgeons, and tobacco interventions in the perioperative period.

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Surgery presents an opportunity for interventions in cigarette smokers that will facilitate abstinence from tobacco. However, little attention has been paid to the role of anesthesiologists and surgeons in addressing tobacco use. To determine the practices and attitudes of these physicians regarding this issue, we sent a postal mail survey to a national random sampling of anesthesiologists and general surgeons engaged in active practice within the United States (1000 in each group). Response rates were 33% and 31% for anesthesiologists and surgeons, respectively. More than 90% of both groups almost always ask their patients about tobacco use, and almost all respondents believed that surgical patients should maintain abstinence after surgery. Most believed that it was their responsibility to advise their patients to quit smoking, but only 30% of anesthesiologists and 58% of surgeons routinely do so. Nonetheless, approximately 70% of both groups would be willing to spend an extra 5 min before surgery to help their patients quit. Barriers to intervention included a lack of training regarding intervention techniques, a perceived lack of effective interventions, and insufficient time to intervene. Intervention opportunities are not exploited consistently in the surgical population; educational efforts directed at physicians in surgical specialties are indicated.
PMID: 15562069 [PubMed - indexed for MEDLINE]

10: Med Care. 2004 Dec;42(12):1186-93.

Do the effects of quality improvement for depression care differ for men and women? Results of a group-level randomized controlled trial.

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OBJECTIVE: We sought to examine whether a quality improvement (QI) program for depression care is effective for both men and women and whether their responses differed. DESIGN: We instituted a group-level, randomized, controlled trial in 46 primary care practices within 6 managed care organizations. Clinics were

randomized to usual care or to 1 of 2 QI programs that supported QI teams, provider training, nurse assessment and patient education, and resources to support medication management (QI-Meds) or psychotherapy (QI-Therapy). PATIENTS:
There were 1299 primary care patients who screened positive for depression and completed at least one questionnaire during the course of 24 months. OUTCOME MEASURES: Outcomes were probable depression, mental health-related quality of life (HRQOL), work status, use of any antidepressant or psychotherapy, and probable unmet need, which was defined as having probable depression but not receiving probable appropriate care. RESULTS: Women were more likely to receive depression care than men over time, regardless of intervention status. The effect of QI-Meds on probable unmet need was delayed for men, and the magnitude of the effect was significantly greater for men than for women; therefore, this intervention reduced differences in probable unmet need between men and women. QI reduced the likelihood of probable depression equally for men and women. QI-Therapy had a greater impact on mental HRQOL and work status for men than for women. QI-Meds improved these outcomes for women. CONCLUSIONS: To affect both
quality and outcomes of care for men and women while reducing gender differences, QI programs may need to facilitate access to both medication management and effective psychotherapy for depression.

Publication Types:
Clinical Trial
Randomized Controlled Trial
PMID: 15550798 [PubMed - indexed for MEDLINE]

11: Cancer. 2004 Dec 1;101(11):2650-9.

Racial differences in knowledge, attitudes, and cancer screening practices among a triracial rural population.

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BACKGROUND: Low-income, minority, and rural women face a greater burden with regard to cancer-related morbidity and mortality and are usually underrepresented in cancer control research. The Robeson County Outreach, Screening and Education Project sought to increase mammography use among low-income, minority, and rural women age > 40 years. The current article reports on racial disparities and barriers to screening, especially those related to knowledge, attitudes, and behaviors. METHODS: A baseline survey was administered to 897 women age > 40 years who lived in rural Robeson County in North Carolina. The sample consisted of three principal racial groups: whites, African Americans, and Native Americans. Survey comparisons were made among racial groups with respect to knowledge, attitudes, and behaviors regarding breast and cervical carcinoma screening. RESULTS: Overall, Native American and African-American women had lower levels of knowledge, more inaccurate beliefs, and more barriers to screening compared with white women. Among the notable findings were that 43% of the patient population did not mention mammograms and 53% did not mention Pap smears as breast and cervical carcinoma screening tests,

respectively; furthermore, compared with white women, significantly fewer African-American and Native American women mentioned these tests ($P < 0.001$). Sixty-seven percent of all women reported that a physician had never encouraged them to receive a mammogram, although 75% reported having received a regular checkup in the preceding year. CONCLUSIONS: Although all low-income rural women experienced significant barriers to receiving cancer screening tests, these barriers were more common for minority women compared with white women. More research is needed to identify ways to overcome such barriers, especially among Native American women. The results of the current study have important implications with respect to the designing of interventions aimed at improving cancer screening for all women. (c) 2004 American Cancer Society

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